TEXAS TECH HEALTH SCIENCES CENTER
Paul L. Foster School of Medicine
GRADUATE MEDICAL EDUCATION
Standard Policy and/or Procedure

TITLE:	Program Expansion Policy
APPROVED:	2/12/2009
REVISED:	3/12/2021
EFFECTIVE DATE:	2/12/2009; 3/12/2021
PURPOSE:	To establish a procedure by which a proposal for program expansion (permanent complement increase) will be reviewed and approved by the Graduate Medical Education Committee (GMEC) and the Designated Institutional Official (DIO).

PROCEDURE STATEMENT: A clinical department with an existing graduate medical education training program that seeks to expand shall follow the procedure outlined below:

1. Discussion regarding the expansion of an existing program shall begin in the clinical department and there should be full faculty support for the proposed expansion.
2. Consultation with the Associate Dean for Graduate Medical Education/DIO is also available and advisable.
3. The GME Program Expansion Request Form must be completed and submitted to the Office of Graduate Medical Education for review by the Graduate Medical Education Committee (GMEC).
    a. An educational rationale must exist to justify the expansion request.
    b. The appropriate financial and infrastructure resources must be in place in concordance with the request for expansion.
4. The Program Director shall present the Request to the GMEC for review and recommendation based on the educational rationale for an expansion request.
5. The Program Director may fill out the request to increase the resident complement in ACGME via WebADS.
6. The request will be forwarded to the DIO for approval.
7. The request will be submitted to the respective residency review committee via ACGME for review and final decision.

Note: Temporary complement increase requests do not require GMEC approval and can be completed directly in WebADS for DIO review, decision, and submission via ACGME.

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Office of Graduate Medical Education

Program Expansion (Permanent Complement Increase) Request Form

PROGRAM (Specialty): _____

Program Director: _____

1. When do you wish to initiate the change? (mm/yy)? _____
2. Briefly describe the proposed expansion and the objective/rationale for increasing the program size.

3. Provide the number(s) of additional residents added each year of the program expansion

PGY/Yr.	1st ( )	2nd ( )	3rd ( )	4th ( )	5th ( )
PGY 1					
PGY 2					
PGY 3					
PGY4					
PGY 5					
PGY 6					
TOTAL	0	0	0	0	0

4. What is the program's current approved complement of residents? Total _____

PGY 1_____PGY 2_____PGY 3_____PGY 4_____PGY 5_____PGY 6_____

5. What is your current complement of filled positions? Total _____

PGY 1_____PGY 2_____PGY 3_____PGY 4_____PGY 5_____PGY 6_____

6. If approved, will this request for permanent complement increase require additional coordinator and program director FTEs? ☐ Yes ☐ No

   If yes, by how many? _____

7. To accommodate the requested increase, do you have sufficient

   Faculty: ☐ Yes ☐ No

   Clinical Material/Patients: ☐ Yes ☐ No

8. What impact will the expansion have on other departments/hospitals?

9. Identify the source of funding (Department, External Source, etc.) required for the expansion.

SIGNATURES:

Program Director: _____ Date: _____

Department Chair: _____ Date: _____